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Editor

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Presenting...

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Linacre's Summer Issue

On Laetare Sunday, Rear Admiral Bartholomew W. Hogan, U.S.N., of Auburndale, Mass., chief of the Navy Bureau of Medicine and Surgery was honored as the year's outstanding Catholic physician. On that occasion he addressed the Guild of St. Luke, Boston, concerning a relationship about which he feels strongly—*Psychiatry and Religion.* We publish Admiral Hogan's address for the information of all our readers.

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Medical practices in the mission field provide an informative article concerning sickness in Africa as written by a priest-doctor serving as a Maryknoll Missioner in Tanganyika. Father Edward Baskerville from Joliet, Ill., received his Doctor of Medicine degree from St. Louis University School of Medicine in 1937. He was engaged in private practice as a physician and surgeon in Wisconsin Rapids, Wis., before entering the Army in January 1942. He served twenty-two months overseas in the European Theater as a flight surgeon and was promoted to the rank of Major before his discharge in 1946. In September of 1947 he entered Maryknoll to study for the foreign mission priesthood. Father Baskerville was ordained in June 1953 and left for the missions of Africa the following month.

•

Some of our long-time readers may be acquainted with the contributions Thomas Linacre made to medicine, but it is a very long time since this journal named for this renowned physician has published any material concerning him. Mr. James F. Gilroy, S.J. a student at the School of Philosophy and Letters, St. Louis University, in studies at St. Stanislaus Seminary, Florissant, Missouri, has prepared an interesting account for us entitled "Who is Thomas Linacre?" It is hoped that some of our doctors might be encouraged from this to delve further into history and produce a full-length biography of their illustrious predecessor.

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Father Gerald Kelly, S.J., who contributes so many valuable opinions appearing on the pages of numerous issues has a busy schedule of Institutes and Workshops as well as answering much correspondence regarding medico-moral problems. In this issue we present "Doctors Ask These Questions" the first of a series answering queries he receives.

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Our book review of *Morale et Mèdecine* by Jules Paquin, S.J., has been prepared by Father Maurice B. Walsh, S.J. who is Prefect of Studies and professor of canon law at Weston College, Weston, Mass. as well as professor of canon law of the missions at the Institute of Mission Studies, Fordham University. We are grateful for these thoughtful comments as the book has been heralded as an important volume on medical morality.

Psychiatry and Religion

REAR ADMIRAL B. W. HOGAN, *Medical Corps USN*

TO DISCUSS psychiatry and religion, let us first specify the terms. Religion, at the present time, is taken in a great variety of meanings — from a firm belief in God, Holy Trinity, and the divinity of Christ—to some lofty but vague sentiment inspired by a symphony, a poem, or a beautiful scene. Erich Fromm speaks even of the religion of no religion. We shall take the term religion according to the definition given by Pope Pius XII, who says that religion is "the natural and supernatural knowledge of God and worship of Him" (Allocution on *Psychotherapy and Religion,* April 13, 1953). This definition is wide enough to be acceptable, not only to Catholics but also Protestants and orthodox Jews.

Psychiatry is a Greek word that literally means healing of the soul or mind. And that is precisely what psychiatry aims at: the healing of people whose mental or emotional life is disturbed. Briefly, one might say that religion deals with the sanctification of the soul, whereas psychiatry is concerned with the health of the soul or mental health. This being so, there would seem to be little or no room for antagonism between religion and psychiatry.

Yet, there still seems to be a more or less widespread belief in the United States that the Catholic Church is opposed to psychiatry. However, Pope Pius XII is of a different opinion. In his address to the Italian National Congress of Nurses (October 2, 1953) the Pope asked: "Is it really necessary to recall the great esteem in which mental health is held in Christian thought and practice?" After giving sound reasons why the Church should be concerned about preserving the mental balance of people and "the recovery of the mind from insanity," he concluded: "If mental health enjoys such esteem in Catholic thought and practice, it is only right that the Church looks with satisfaction at the new paths being opened by psychiatry in this post-war period."

These words do not mean, however, that the Pope approves the practice of each and every psychiatrist, nor do they mean that he subscribes to every psychiatric theory. Psychiatry, is divided into several schools or systems. For our purpose, we wish to single out certain forms of psychotherapy and more in particular, the Freudian school of psychoanalysis, because this school has come under heavy fire from Catholic as well as non-Catholic sides. As for the attacks launched by Catholics in the United States, people spoke of a declaration of war against psychoanalysis. A few years ago an Italian Monsignor, Pericle Felici,

came out in the bulletin for the Roman clergy with a violent denunciation against Freudian analysis.

Obviously, Felici's denunciation raised a great deal of controversy. In the midst of this controversy, Pope Pius issued two statements (Sept. 14, 1952—April 13, 1953) which did much to clear the air. In the first, His Holiness denounced the theory of pansexualism. The second allocution was of still greater importance, because the Pope goes right to the heart of the problem. Allow me to quote the opening phrases of this highly significant document and then add a few paraphrases.

"Science affirms," the Pope says, "that recent observations have brought to light the hidden layers of the psychic structure of man and tries to understand the meaning of these discoveries, to interpret them and render them capable of use. Psychiatrists speak of dynamisms, determinisms, and mechanisms, hidden in the depths of the unconscious, endowed with immanent laws whence are derived certain modes of acting. Undoubtedly, these begin to operate within the subconscious or the *unconscious,* but they also penetrate into the realms of the conscious and determine it. Psychiatrists claim to have devised *methods* that have been tried and recognized as adequate to scrutinize the mystery of the depths of the soul, to elucidate them and put them back on the right road when they are exercising a harmful influence. These questions, which lend themselves to examination of scientific psychiatry, belong to your *competence.*

"But *theoretical* and *practical* psychiatry, the one as much as the other, should bear in mind that they cannot lose sight of the truths established by *reason* and by *faith,* nor of the obligatory precepts of *ethics.*"

This paragraph of the papal statement clearly distinguishes between three aspects of the analytical systems:

1. The scientific part which is concerned with establishment of the psychic dynamisms that operate within the depths of the unconscious;
2. The therapeutic methods that are used to cure the patients;
3. The philosophical, theological, and moral superstructure that is found in many systems of psychoanalysis.

Let us discuss these three features briefly, again limiting ourselves to Freudian psychoanalysis.

(1) THE PSYCHOLOGICAL THEORIES

The main theory of psychoanalysis concerns the existence of a dynamic unconscious and its various mechanisms. Of course, everyone must admit that there is an unconscious; there are thousands of experiences stored in our minds of which we are at this moment not aware at all. But, according to the analytical theories, some of these unconscious elements are of a dynamic nature—that is to say, they are still active, even though we are unaware of them. These unconscious elements may be re-

pressed by the individuals but show themselves in clever disguise — for instance, in our dreams — they may cause slips of the tongue, mispronunciations — they may be even more harmful, inasmuch as they may cause neurotic disturbances interfering with our normal adjustment to life.

The concept of a dynamic unconscious, with its various mechanisms, such as repression and the super-ego, the restraining and punishing force, and a few other concepts form the backbone of analytical theory. In order to prove the existence of such dynamisms, the analysts use the technique of free association and dream analysis.

Now, according to Pope Pius XII, the question, whether such and similar dynamic forces exist in man's unconscious, is *as such* irrelevant to Catholic philosophy or religion. It is a matter for the psychiatrists to decide whether the theory is based on sufficient evidence; "these questions belong to your (the psychiatrists') competence"—the Pope says.

(2) THE PSYCHOTHERAPEUTIC METHODS

The main therapeutic methods of psychoanalysis are catharsis, or the lively recall of the unconscious material that is taken to be the cause of a neurotic disorder, and the interpretation of the so-called transference phenomenon. In the patient-doctor relationship, the patient's attitude toward the therapist becomes emotionally charged; the doctor becomes an object of love or hatred, because he represents in the eyes of the patient one or another figure that played an important role in his life. The aim of the therapist is to interpret this transference phenomenon; in doing so he uses empathy, the function by which one re-experiences another person's experiences. We may say in passing that the knowledge imparted by empathy is in some respects similar to what Saint Thomas Aquinas calls knowledge by connaturality.

With regard to the therapeutic methods, Pope Pius repeats the same remark as he made concerning the analytic theories; "*as such* these methods have nothing to do with religion and it is up to the psychiatrists to find out whether they work or not."

In both cases we said: *as such*. That is to say, psychoanalytic theories or therapeutic methods are of no concern to the Church, on condition that they are not opposed to reason, faith, or ethics.

And that brings us to a discussion of the third feature of psychoanalysis, its superstructure.

(3) THE SUPERSTRUCTURE

It is a remarkable fact that Freud started his career as a medical man and ended up as a theorizer about religion, his first publication being "Studies in Hysteria" and his last "Moses and Monotheism." He began with presenting a new therapeutic method, but rather soon he developed a dogmatic system comprising the whole of philosophy and theology. To Freud, God was a father-substitute used by immature people who, unable to cope with the difficulties of life, regress to an infantile stage

in which period they used to rely upon the assistance of their parents. And religion, therefore, is a sign of mental immaturity, or compulsive neurosis which humanity should outgrow.

Obviously, such theories are unacceptable to Catholics, Protestants and orthodox Jews as well.

Present-day psychiatrists are usually more cautious than the master of Vienna, but many of them cannot refrain from theorizing about the meaning of life and of existence. Some of them hold that psychoanalysis has changed our insight into religion. This is absurd. God is still in His Heaven and dogmas are still dogmas. The most we may say is that analysis has shed some light on certain aspects of religious phenomena which enables us to approach the religious problems of a *particular* individual with a better insight.

Catholics, and those of other religions, must reject forcefully the futile attempts of the so-called new religionists who try to replace religion with psychiatry. Religion covers the entire life of all people; psychiatry may be a help for certain periods of life of some individuals. Psychiatry never can—nor will—replace religion.

One of Freud's chief concepts was that of *libido*. There is some uncertainty about the exact meaning of this term, but a rather common opinion is that libido in the Freudian sense refers to bodily and more specifically sexual pleasure. Some authors try to whitewash Freud and say that Freud did not claim that all other forms of pleasure and love *are* the same thing as sexual pleasure, but that they should be *regarded* as the same thing. Whatever the value of this rather sophistic distinction may be, the general opinion — including that of Pope Pius—is that Freud advanced the theory of pansexualism. By pansexualism is meant the belief that the main driving force of human nature is the sex drive. Evidently, such a theory is no longer purely psychological, but enters into the field of philosophy, because it purports to explain man's innermost nature.

Now, the Pope rejects most emphatically "the pansexual theory of a certain school of psychoanalysis;" —he rejects it as "not proved — in fact, incorrect." (Allocution, September 14, 1952.)

This condemnation makes it clear that pansexualism is unacceptable to Catholics. And we may add that other competent psychiatrists, such as, Adler and Horney, disagree fully with Freud on this question.

At this juncture two questions are in order. The first is: can the philosophical and theological superstructure be removed from psychoanalysis so as to make it acceptable to Catholics? The second is: what is the value of religion for psychiatry?

(a) Can psychoanalysis be made philosophically neutral?

With regard to the first question, a number of Catholic authors answer in the affirmative. To mention a few: Dalbiez, Zilboorg, Karl Stern, Nuttin, and several French analysts. From what we have said

before, it appears that Pope Pius XII is of the same opinion.

Stern goes even so far as to say that the psychological theories and methods of psychoanalysis fit in better with Christian philosophy than with Freudian materialism. Hence, it appears possible, theoretically, to baptize and christianize psychotherapy, or—if you wish—to "defreud" Freudianism. *Theoretically,* I said, because in practice we run into some difficulties.

In practice, the psychiatrist himself is to be considered. Let us suppose that he adheres to a system that tries to be strictly scientific and therapeutic, avoiding all philosophizing. Yet, the psychiatrist has, of course, his own philosophy, his outlook on life, on religion, on the natural law and so forth. And it can be expected that, during the process of transference, this outlook on life transpires somehow and colors the treatment. It has not even to be formulated; during therapeutic treatment even silence speaks.

This subtle process operates in the case of a Catholic psychiatrist, but it does also operate in the case of a man who does not believe in the Divine Law and for whom certain behavior patterns and habits after all are not really objectionable. Here lies a practical danger. It is this danger that the Pope has in mind when he warns that "theoretical and practical psychiatry, the one as much as the other, should bear in mind they cannot lose sight of the established truths."

(b) The second question concerns the positive contributions of religion and psychiatry.

When speaking of religion, we must once again emphasize the fact that religion does not only consist in the acceptance of certain religious truths, but also in the observance of God's commandments and precepts.

In that sense, religion has first of all a preventive value, i.e., it is an excellent means to keep healthy souls healthy. For it teaches us self-control and that is the best manner to achieve and to keep peace of mind (Liebmann) or peace of soul (Sheen) or peace of heart (Jrala).

However, we must admit that confidence in God, faith and the observance of the commandments are not always an absolute safeguard against a mental breakdown. Very religious people may become mentally ill, because the stress and strain of life may become too great a burden to bear. Once a person has become mentally or emotionally disturbed, religion alone will not restore, in most cases, his mental balance. He will need the help of a sound psychiatrist.

But during his treatment, religion is again a very valuable asset. In fact, several psychiatrists use religion to great advantage in the treatment of their patients. Far from calling religion a compulsive neurosis, Carl Jung believes in the therapeutic function of religion. "Among all my patients," he says "there has not been one whose problem in the last resort was not that of finding a religious outlook on life. It is safe to say that every one of them fell ill because he had lost that which the living religions

of every age have given to their followers, and none of them has been really healed who did not regain his religious outlook."

I wish to mention here also another psychiatrist who made ample use of religion in his treatment of the mentally ill: the Italian Vico Necchi who died in 1930 in high repute of sanctity and who probably will be beatified before long and, thus, become the patron saint of psychiatrists.

It would take us too far afield to point out the advantages of religion in the treatment of the mentally ill; one or another point may suffice.

1. Strong religious conviction gives the individual a feeling of being wanted, of belongingness. According to all psychiatrists, the most common neurosis of our times is anxiety with feelings of insecurity. It is not here the place to enter into the reasons why this is so. Fact is that many people wonder whether life is worth living; they are burdened under the fear of the unknown, they suffer from the emptiness of life, the feeling of not belonging anywhere. They think, with Macbeth, "Life is but a tale told by an idiot, full of sound and fury, signifying nothing." Or in the words of the poet "W. H. Auden:

We move on
As the wheel wills—
We go on talking
Many about much, but remain
alone.
Alive, but alone, belonging—
where?—
Will nightfall bring us
Some awful order?
It is getting late.
Shall we ever be asked for?
Are we simply
Not wanted at all?"

Are we not wanted? Do we belong anywhere? This is the essence of the questions which, in an infinite variety, are asked the psychiatrist.

The Catholic psychiatrist has the complete answer — the answer which, in condensed form, is found in the catechism where it speaks of the purpose of life. God wants us; we belong to Him.

2. Catholics possess a means of sanctification that sometimes is compared with the analytical procedure, namely, confession. Of course, there is a great difference between the two; the patient on the couch confesses to a man, the penitent in the confessional confesses to God; the former may get rid of unconscious material, the latter gets rid of conscious material. But in both cases, there is an unburdening of the soul of bothersome and guiltful material.

The problem of guilt has been the subject of much misunderstanding. Yet this misunderstanding disappears, when we make the distinction that was clearly made by Pope Pius XII in the allocution on psychotherapy which we mentioned before. We should distinguish between guilt and the genuine feeling of guilt that accompanies it and, on the other hand, an irrational or morbid feeling of guilt.

Guilt is something objective — the result of having transgressed the Divine Law, and a normal per-

son is perfectly conscious of his sin; that is, the genuine sense of guilt. Now, only contrition and sacramental confession can take away objective guilt. After confession a normal person ceases also to feel guilty; even though he still may feel remorse for his sins, he feels happy for being free of guilt.

This is beautifully expressed by the great penitent of the Old Testament, David, in the 31st Psalm —which I wish to relate to you, with a slight transposition of the verses so as to make the sequence of the penitent's experiences clearer.

"As long as I *would not speak,*
my bones wasted away groaning all the day,
For day and night your hand
was heavy upon me; my
strength was dried up as by
the heat of summer.
Then I *acknowledged my sin* to
you, my guilt I covered not.
I said: "I *confess* my faults to
the Lord: and you took away
the guilt of my sin.
Happy is he whose fault is taken
away, whose sin is covered.
Happy the man to whom the
Lord imputes not guilt, in
whose spirit there is no guile."

But there is also a morbid, irrational, neurotic feeling of guilt. In some people the feeling of anxiety may continue after the sin is forgiven, or it may even exist without any apparent guilt. In such cases the individual can no longer be regarded as a penitent, but must be considered a patient who should be treated by psychiatry.

I hope that I have made it clear that if psychiatry, psychotherapy, psychoanalysis are devoid of atheistic and materialistic philosophy, show respect for natural and revealed religion, abide by the precepts of the natural law, there is not only no opposition between psychiatry and religion but we can go a long way toward integrating its findings into Catholic thought.

If these conditions are fulfilled, we may repeat the words of our Holy Father which I quoted in the beginning: "The Church looks with satisfaction at the new paths being opened by psychiatry in this post-war period."

Further comment following these words is anti-climax. I write in my capacity of physician responsible for the physical and mental health of the men of that honored institution, The U. S. Navy. I speak to you as a proponent of the conservation of man — body, mind and spirit. It is as Chesterton says: "Strange to see people interested in the ruins of an old cathedral and not interested in the ruins of man." We, in medicine, are conscious of man's dignity and of his spirit. It is the latter which motivates him and we are interested in the motivation of man toward God and country; without this motivation in a healthy population the nation cannot endure.

Opinions or assertions contained in the foregoing are the private ones of the author and are not to be construed as official or reflecting the views of the Navy Department or the Naval Service at large.

Who is Thomas Linacre?

James F. Gilroy, S.J.

Few physicians have ever done more for their profession than Thomas Linacre. When he received his M.D. at the beginning of the fifteenth century, the practice of medicine in England was carried on largely by "a great multitude of ignorant persons, of whom the greater part had no insight into physic, nor in any other kind of learning; some could not even read the letters on the book, so far forth, that common artificers, as smiths, weavers, and women, boldly and accustomably took upon them great cures to the displeasure of God, great infamy to the faculty, and the grievous hurt, damage, and destruction of many of the King's liege people."[1] Not too long before this, Geoffrey Chaucer in the Prologue to his *Canterbury Tales* spoke of a doctor of his time: "He watched sharply for favorable hours and an auspicious ascendant for his patients' treatment, for he was well grounded in astrology."[2]

Linacre was too intelligent not to perceive the immense need for reform and too conscientious not to do his best to bring it about. To combat the ignorance of scientific medical methods he gave lectures at Oxford and established readerships in medicine at Oxford and Cambridge. In order to limit the practice of medicine to competent physicians he founded the Royal College of Physicians to license doctors and regulate their practice and to punish irregular practitioners.

Born about 1460, young Linacre studied at the monastery school of Christ Church, Canterbury, under the learned monk William Selling and then proceeded to Oxford. In 1488 he accepted the offer of traveling to Italy with his old teacher, Selling, who had been appointed Henry VII's ambassador to the Pope. At the most famous of the Italian Universities, Bologna, Florence, Rome, Venice, and Padua, Linacre spent about ten years, associating with and studying under many of the leading figures of the Italian Renaissance, such as Hermolaus Barbarus and the future Medici Pope, Leo X. At Rome

Editor's Note: *The above thoughtful account of this great physician for whom our journal is named reminds us—and not for the first time—that there seems to be no full-length biography of Thomas Linacre although there are scores for his famous student and contemporary, Thomas More. A definitive biography and at least one popular biography is highly desirable. It would not be an easy task. It does look interesting. A rather good bibliography of source materials on Thomas Linacre is given in the first part of the article on him in the book Great Catholics.*

[1] From the Charter of the College of Physicians, quoted by Anthony Bassler, "Thomas Linacre," *The Linacre Quarterly*, I (1933).

[2] Geoffrey Chaucer, *The Canterbury Tales*, edited by John Tatlock and Percy MacKaye for modern readers (New York: Macmillan & Co., 1946), p. 8.

Linacre's collation of manuscripts in the Vatican libraries gained him a reputation as an authority in Humanistic learning. During the course of these studies he became so interested in the ancient writers on medicine that he directed his studies to this field and earned a doctor of medicine degree at the University of Padua.

After his return from Italy Linacre was chosen tutor and physician to Prince Arthur and teacher of Italian to Princess Mary. Soon he became domestic physician to King Henry VII and in due course was made King's Physician to Henry VIII. But all this court favor did not turn his attention from what had become a dominating interest in his life—the establishment of a firm foundation for medicine as a respectable profession in England. His first steps in this direction were the medical lectures he gave early in the century at Oxford. Soon, however, he saw that it would be better to carry on his work from London.

When by 1509 he had become firmly established at Court, he gave himself even more completely to the task. At last, in 1518, he received the reward for his long efforts, a royal charter establishing the Royal College of Physicians of London. He became its first President. "It was Linacre's zeal for the advancement of medicine that led him to obtain by Royal Letters Patent a charter from King Henry VIII made out to himself and five other physicians for the foundation of a College of Physicians of London, for the regulation of the practice of physic in London and for seven miles around, and for the punishment of offenders. Four years afterwards these privileges and responsibilities were confirmed by statute and extended to the whole country."[3] Linacre financed the whole project out of his own fortune, since the royal charter made no provision for support.

The importance of this establishment can be seen, for "no professional foundation, at home or abroad, stands higher today in public estimation than this College. Its Fellowship is recognized as evidence of culture, professional skill, and high character: one might say that by it the attributes of the founder are preserved,"[4] and "it is impossible not to recognize a strong constructive genius in the scheme of the College of Physicians, by which Linacre not only first organized the medical profession in England, but impressed upon it for some centuries the stamp of his own individuality."[5]

His last great contribution to the advancement of medicine was the establishment shortly before his death of readerships in medicine at Oxford and Cambridge. Unfortunately, however, "owing to neglect and bad management of the funds, they fell into useless-

[3] W. J. O'Donovan, "Thomas Linacre." *Great Catholics*, edited by Claude Williamson, O.S.C. (New York: Macmillan & Co., 1939) p. 87.

[4] J. P. Pye, "Thomas Linacre, Scholar, Physician, Priest," *Twelve Catholic Men of Science*, edited by Bertram *Windle* (London: Catholic Truth Society, 1914), p. 9.

[5] *Encyclopaedia Britannica*, 9th ed., Vol. XIV. Article, "Thomas Linacre."

ness and obscurity." But "the Oxford foundation was revived by the university commissioners in 1856 in the form of the Linacre professorship of anatomy. Posterity has done justice to the generosity and public spirit which prompted these foundations."[6]

In 1520 Linacre, unlike Chaucer's physician, whose "studie was but litel on the Bible,"[7] culminated a thoroughly Christian life by being ordained a priest of the Catholic Church. Four years later, on October 20, 1524, he died and was buried in St. Paul's Cathedral, London. He had lived his sixty-four years of life to the full. Few before or after him can display a comparable record of intellectual and cultural achievements.

Thomas Linacre was a great physician in his time; of this there can be no doubt. Among his patients were numbered two kings, Henry VII and Henry VIII, a prince, a future queen, the Lord High Treasurer, Sir Reginald Bray, Cardinal Wolsey, and other notables in the realm. Erasmus considered him the introducer of medical science into England. In our own times, "Sir George Newman in his Linacre Lecture . . . (asserted) that to him we owe our conception of the splendor and amplitude and the high purpose of the science and art of medicine."[8] These qualities alone would be sufficient to allow the British and American medical men of today to look with pride to Linacre as a Father of English Medicine.

Besides being a great physician, Thomas Linacre was also a great scholar. He knew Greek thoroughly and was famous for the purity of his Latin style. He included among his students such outstanding personages as the Prince Arthur already mentioned, the Princess and future Queen Mary, Sir Thomas More, the Saint and brilliant Humanist, and Erasmus, the greatest scholar of the age. The leading scholars of Europe in his day united in their praise of Linacre as the first great English Humanist as well as the outstanding physician of the time. Indeed, his intellectual gifts were such that Erasmus wrote: "What can be more acute, more perfect, or more refined than the judgment of Linacre,"[9] and "Linacre is as deep and acute a thinker as I have ever met with."[10] It is indeed a credit and high compliment to the profession that such a man should devote himself to the practice of medicine at a time when it was scarcely a respectable pursuit.

Linacre left no original works on medicine in writing, but "his Greek scholarship . . . was applied to purifying the great works of classical science and medicine from medieval accretion,"[11] notably such works of Galen as *De Sanitate Tuenda, De Pulsuum Usu,* and *Methodus Medendi.*

But it is less for any specific contribution to medicine than for the man himself that we should be grateful. This at least was the

[6] *Ibid.*
[7] Prologue, l. 438.
[8] O'Donovan, *op. cit.*, p. 83.
[9] *Ibid.*, p. 84.
[10] Pye, *op. cit.*, p. 15.
[11] Douglas Bush, *The Renaissance and English Humanism* (Toronto: University of Toronto Press, 1939), p. 72.

opinion of Sir William Osler, the great modern physician and founder of the Johns Hopkins University School of Medicine. "Many of the greatest physicians," said Osler, "have influenced the profession less by their special work than by exemplifying those graces of life and refinements of heart which make up character. These have been the leaven that raised our profession above the level of business. Of such as these Linacre was one."[12]

[12] O'Donovan, *op. cit.*, p. 84.

WHEN SOMETHING GOES WRONG in body or in soul, man is in pain; his work in the world is interrupted and may be left unfinished. It is the part of doctors and nurses to co-operate in the plan of God by helping man over these difficult times, to relieve the pain and to cure the sickness by the use of natural means which God has created and placed at the disposal of man.

Doctors and nurses get closer to the heart and spirit of man than anyone else except priests. More than anyone else, they understand the wonders of the human body, how it works, and what interferes with its well-being. God gives them such wisdom and skill because He loves man so much and desires right order to be restored.

Christ became man in order to die for men; and He rose from the dead in order to raise them up with Him in perfect wholeness of both body and mind. We are living in the age of the Risen Christ. Doctors and nurses should live with Him and for Him as did the Apostles and other miracle-workers who worked their cures in His name, in His power, and for His divine purposes.

League of The Sacred Heart
Apostleship of Prayer
(Intention for June—Doctors and Nurses)

The *Directives* on Artificial Insemination

In recent years many books on medical ethics have included the text of our ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HOSPITALS. *This has given rise to a problem that was first called to our attention by a book review that appeared in an influential clerical publication entitled* THE AUSTRALASIAN CATHOLIC RECORD. *After the publication of this book review, Father Kelly wrote an explanatory letter to the Editor of* THE AUSTRALASIAN CATHOLIC RECORD. *This letter, which was published in the* RECORD *for April, 1955 (pp. 162-63), is of considerable importance to all who use textbooks such as those by Father Kenny, Father McFadden, etc. The text of the letter is as follows:*

"The October, 1954, number of the *Record* (pp. 360-62) carries a review of *Medical Ethics*, by John P. Kenny, O.P. The reviewer, while praising Father Kenny for basing his treatment of artificial insemination on the Allocution of Pope Pius XII, criticizes our own publication, *Ethical and Religious Directives for Catholic Hospitals*, for being 'a little out of date' on this point. The criticism is justified, since it is based on the *Directives* as published in Father Kenny's book; but it should be noted that this book does not give a complete picture of the *Directives* as actually and officially published by the Catholic Hospital Association of the United States and Canada. Since this matter concerns an official publication of a very large association of Catholic hospitals, and since this publication represents the fruit of painstaking collaboration of distinguished theologians and physicians, a further clarification seems in order.

"*Ethical and Religious Directives for Catholic Hospitals* is a code of concise statements concerning the proper moral and religious care of patients. It contains not only the directives themselves but also a number of explanatory reference notes. Had Father Kenny printed the reference note for the directive on artificial insemination, your reviewer's criticism might not have been made.

"The pertinent directive reads as follows: '*Artificial Insemination* of a woman with semen of a man who is not her husband is morally objectionable. Likewise immoral is insemination even with the husband's semen, when the semen is obtained by means of masturbation or unnatural intercourse. Advising or co-operating in these practices is not allowed in this hospital'. The pertinent explanatory note in the first printing of our booklet (March, 1949) gave this explanation: 'The statement in the code includes only the forms of artificial insemination that are *certainly* immoral. Other methods of insemination between husband and wife are still debated by theologians. We hope to present complete information on the subject in an early number of *L. Q.* [*The Linacre Quarterly*]. In the meantime, physicians may consult McFadden, *Medical Ethics for Nurses* (1946), p. 67, for a brief statement of methods that may be considered as at least probably licit'.

"As you know, the Allocution on artificial insemination was given on September 29, 1949. At that time we discussed the advisability of rewording the directive, and we decided to make no change in the directive itself until such time as the entire booklet would be revised. But the explanatory note—which, it must be kept in mind, is an integral part of the booklet as we published it—was changed to read as follows:

'The statement in the directives includes only those forms of artificial insemination that were considered certainly immoral at the time the code was published. Since that time we have had the official statement of Pope Pius XII, Sept. 29, 1949. According to his declaration, the only permissible forms of artificial insemination are those which are used as aids to natural marital intercourse. For the English version of the Pope's statement, see *Linacre Quarterly*, Oct. 1949, pp. 1-6. For complete explanation, see Moral Aspects of Sterility Tests and Artificial Insemination, *MMP*, II, 14-22'. (*The Linacre Quarterly* is the official journal of the Federation of Catholic Physicians' Guilds in the U.S.A. *MMP* is an abbreviation for our booklets entitled *Medico-Moral Problems*.)

Yours, etc.
Gerald Kelly, S.J."

Sickness and the African

Edward M. Baskerville, M.M., M.D.

It has oft been stated that progress in Africa is hindered by three big problems: ignorance, poverty and disease. Unfortunately they are so closely interrelated that they present a formidable obstacle to anyone seeking to solve them. But one thing is certain: sickness in Africa presents an opportunity and a challenge to all who would heed the precept of charity. To approach it one must think not only in terms of sickness in general, but also of the problems peculiar to sickness in the African. And when I refer to the African, I refer particularly to the Luos, Bakuria and Basambiti who live in the vicinity of Kowak Mission.

First of all, the African is born into a relatively hostile environment where less than half of the babies reach their first birthdays. He is raised in the shadow of ignorance and schooled in the pagan practices of magic and witchcraft. He is fed a monotonously starchy diet of cereals supplemented by a few greens and a bit of meat. He has no knowledge of hygiene and is surrounded by poor sanitation. Even the use of the simple outhouse is ignored. Outside of the rainy season he is perennially short of water, and the surface water he must use is usually contaminated. He must work under a fierce tropical sun to wrest a precarious living from a poor, impoverished soil. And, finally, he lives in a climate better suited to the growth of insects, parasites and bacteria than to his own nature.

And so we find that sickness is more common in the African than robust health. And, contrary to our opinions, he is not stricken with the myriad of tropical diseases exclusively but suffers the more common ailments like colds, headaches, pneumonia, and such, just like the average American. One can only guess at the millions suffering from malaria, bilharzia, typhus fever, intestinal parasitic infestations, relapsing fever and the nutritional deficiencies. In addition there are other diseases which thrive in a tropical environment, diseases such as tuberculosis (sometimes referred to as No. 1 killer of Africa), leprosy, syphilis, yaws, yellow fever, filariasis, kala-azar, African sleeping sickness, typhoid fever, and amebic dysentery.

In general the African has a much lower resistance to disease than the white man. That is why such diseases as tuberculosis tend to run a rapid, fatal course. Still he has some natural advantages. His dark skin protects him from the ravages of the tropical sun. His placid, good-natured temperament conserves his expenditure of limited energy. His simple life precludes many of the hazards of

modern civilization. For instance, as a result of his simple, restricted diet digestive disorders such as peptic ulcers are a rarity; obesity is seldom observed; gall bladder disease is all but unknown; diabetes is most uncommon; and but few cases of high blood pressure are noted. Appendicitis, so common in the United States, is seldom seen in the African. While it is known that tumors do occur in the African it is rare to see them in dispensary work. Perhaps this scourge of modern times belongs only to civilization also.

As regards infectious diseases the African has his troubles too. Chicken pox, measles, mumps and whooping cough are very common, the latter often terminating in pneumonia and death in infants. On the other hand diphtheria and scarlet fever are relatively rare diseases while small pox epidemics are sporadic. Rheumatic fever occurs in African children also but it seems to be less commonplace and runs a milder course. But it is still a killer. I recall one of our early African patients, a twelve year old girl with a rheumatic mitral stenosis which precipitated decompensation with pronounced dyspnea. Under rest and Digitalis she improved rapidly and was sent back to her village with a supply of Digitalis and instructions to return for a periodic check-up. With the return of good health both medicine and advice were forgotten. Months later she returned, in extremis, and died shortly after receiving the Last Sacraments.

Injuries of violence are relatively rare, although we occasionally see snake bites or injuries from wild animals such as a rhino goring. In the past year we did not see one fracture in our Kowak Dispensary, although one of the school boys did dislocate his elbow playing soccer. Lacerations, however, are common, most of them following careless use of the panga, the large, wicked-looking African knife of many uses. Often to get at such wounds one must clean off cattle dung or muddy herb mixtures. Infections are common and healing is quite slow. Burns likewise are common, particularly among small children, as all food is cooked over open fires. Amputations present their own problems as demonstrated recently when an elderly African presented us with an amputated thumb to be replaced. It took a half an hour's gentle persuasion on the part of Maryknoll's Sister Mary Agnes Jude, R.N., to convince this trusting soul that his confidence was flattering but unwarranted.

Through ignorance and long-established pagan practice the sick African often consults a herb doctor or a witch doctor before reporting to a modern dispensary. Often he arrives far advanced in his illness, and many die enroute or shortly after arrival. But for those who arrive in good time there still remains the problem of diagnosis. First, there is the language barrier. Even after this has been hurdled we find that the African speaks in broad general terms. ("My stomach is eating me." "A cough has grabbed me.")

Finally, the African patient is passive and inclined to be disinterested in his illness, and he is totally unable to associate his symptoms. As an example, he'll complain of sore glands in his armpit, but will omit any reference to the tell-tale tache noir of tick fever around his waistline—unless you specifically ask him. Worst of all, he'll probably have one or more chronic diseases which confuse the picture of his present illness. In this connection a good laboratory is absolutely essential, yet they are few and far between in East Africa, even in the larger cities, for they require sizable investments for establishment, and highly trained personnel for operation.

The African is a fatalist. One is often amazed at his lack of a will to live. So often we see an African die of what seems to be insufficient cause — he is just resigned to death. He is not as stoical as many assume and while he often exhibits a high degree of pain tolerance, he has no more love for the needle or the knife than the white man. But he is always a trusting, docile and submissive patient, even if not entirely cooperative. Unhappily, in a sense, he has a fanatic faith in a "sandan," a hypodermic injection. One day I drove out into the veldt to see a woman suffering from hemorrhage and shock following a miscarriage. After examining her I advised that she return to the Kowak Dispensary with us in our lorry. She agreed. To minimize the danger and discomfort of travel I administered a "sandan." That was it!—She was cured!—and she refused to leave the village. God watches over His own—she lived!

After the question of diagnosis, we come to the problem of treatment. The African is an impatient patient — after all he's used to magic. So he expects quick results, and this complicates the treatment of all illnesses. In chronic illnesses such as syphilis or leprosy it further complicates the problem as they require long periods of treatment. So we can expect many of our treatments to be abandoned. By his own logic the African reasons that if a little medicine is good, more is better. So we sometimes find him taking several days' supply of medicine at one time. Recently an elderly African woman tried this procedure with some native herbs. She died, while the non-plussed herb doctor drank his medicine publicly to prove it was not poison. Perhaps, worst of all, is the discouraging thought that after an African is cured of his illness he will soon become reinfected or fall victim to some other malady equally as bad.

Contrary to popular opinion the African has his mental problems too. Accurate diagnosis of these afflictions is most difficult while institutional care is woefully inadequate. A United Nations survey indicates that the incidence of mental disease in the African is less than half of that in more civilized countries. So today the mental patient is tolerated in his village, sometimes manacled if he proves to be obstreperous. Recently one patient ran amok near the mission, armed with a panga. He was promptly speared to death by the villagers.

It is apparent that medical care in Africa must be approached from a public health viewpoint. In this connection, Sister James Elizabeth, R.N. has recently opened a maternity unit at Kowak. In addition to providing the usual amenities, she will train young African girls in the basic principles of village mid-wifery. Also, a leprosy clinic has been initiated under Maryknoll's Sister Catharine Maureen, R.N. With limited facilities plus a high incidence of leprosy in this locality there is already a long waiting list. But for these efforts much remains undone. For example, no effort at all is made to cope with the problems of defective vision or impaired hearing. Dental care is unknown, and no one would dare to start doing tonsillectomies—the work would be endless. Practically every African baby presents a pot-belly with an umbilical hernia. But no one thinks of repairing these hernias — the Africans regard them as a thing of beauty and a joy forever!

In spite of all the problems in caring for the sick African the work has its compensations. Andre Paré, the great French surgeon, once observed that we merely tend the sick, that God heals them. In this we concur, but it is soul-satisfying work to be an active partner in the Divine Plan. And deep within the heart of every humanitarian worker in Africa lies the hope and conviction that among our African people will one day arise those dedicated workers to pursue the work and ideals which we are striving to establish. Such is the history of progress—and the missions!

Author's Note: For those seeking an introductory book on the subject of disease in Africa, the author recommends, *The Sick African* by Doctor Michael Gelfand, published by Stewart Printing Company, Ltd., of Capetown, South Africa, and to which the author acknowledges a debt for both inspiration and information.

THE WHITE MASS is scheduled for October 18 to honor St. Luke, Patron of Catholic Physicians. Plan to assist at Mass with your Guild for this special observance.

Doctors Ask These Questions

. . . Gerald Kelly, S. J.

During the last decade I have given many talks to and conducted many informal discussions with medical students and doctors. On these occasions questions were usually asked, sometimes orally, sometimes in writing. I have kept a fairly accurate record of these questions, and I believe that other doctors besides those who presented the questions or listened to the discussion of them would be interested in seeing them.

I am giving here the questions that are most typical at doctors' meetings. To these I am adding a few that are rather unusual. Regarding the typical questions, I should like to make this preliminary observation: almost all of them are already answered rather completely in the booklets entitled *Medico-Moral Problems.* I have found, however, that many Catholic doctors either do not have these booklets or, if they have them, do not have time to read them. As for the unusual questions, these are generally not covered either in my booklets or in other texts on medical ethics. I am including them in my list, not merely because they are unusual and seldom answered in print, but also because they seem to have a special practical value.

1. *Is a physician morally bound to tell a patient he is dying so that he may prepare properly for death?*

This question is answered in *Ethical and Religious Directives for Catholic Hospitals,* and in the *Code of Medical Ethics for Catholic Hospitals.* The pertinent text of both *Code* and *Directives* reads as follows:

"Everyone has the right and the duty to prepare for the solemn moment of death. Unless it is clear, therefore, that a dying patient is already well-prepared for death, as regards both temporal and spiritual affairs, it is the physician's duty to inform or to have some responsible person inform, him of his critical condition."

Proper understanding of this directive requires the consideration of many factors; hence a few brief observations are in order.

First, it should be noted that the directive concerns a real moral duty, binding in conscience. That duty belongs primarily to the physician because it flows naturally from the physician-patient relationship. But, as the directive clearly indicates, the doctor can fulfill this duty by having someone else communicate the required information, e.g., the chaplain, a special friend of the patient, etc. It seems to me, however, that it is seldom advisable for the doctor to use an intermediary. Doctors often have a special facility for giving this information — call it the "bedside manner" if you wish, or call it the

grace of office. Moreover, when the proper physician-patient relationship exists, the patient usually expects to receive such information from his doctor; and the very fact that the doctor himself gives the information tends to increase the confidence of the patient in the doctor.

Secondly, the directive refers to both *spiritual* and *temporal* preparation for death. By temporal preparation is meant the paying of one's debts, arranging one's business affairs, making a will, etc. Obviously, it is not the physician's business to advise his patients in these matters. But it is the physician's duty to see that the patient has sufficient information about his condition to take care of these affairs of his own volition.

For a Catholic, the main spiritual preparation for death is the reception of the sacrament of extreme unction. This sacrament can and should be given not only to patients in *imminent* danger, but also to those who are in the *probable* danger of death from illness: that is, their condition is such that there is a good chance that they will die, even though there may be an equally good chance that they may recover. When dealing with a Catholic patient, therefore, a doctor certainly has the duty to let the patient know that his condition is sufficiently critical to warrant the reception of extreme unction. But, supposing that the patient receives extreme unction, is there any obligation to give him more definite information, e.g., that there is no hope of recovery, that he very likely has only a month or two to live? It seems to me that, if the patient sincerely wants such information, the doctor is obliged to give it. Whether it would be advisable to *volunteer* such definite information would depend on many circumstances, especially on the judgment of what would help the patient to make a better preparation for death; and I doubt that any general rule can be given on this point.

What about non-Catholic patients, patients with no religious convictions, etc.? Even these patients, as the directive indicates, have the duty to prepare for death; and it is rare indeed that a man has no realization of this. Moreover, all have the right to know that the time has come to make this preparation; hence, whatever be his patient's religious convictions or lack of them, the doctor should see that they have the information. In fact, those who seem to be most callous spiritually are most in need of the information that their condition is critical.

Neither the doctor's question nor the wording of the directive is precisely concerned with telling the dying patient the *nature* of his illness. There is a special problem, it seems, regarding cancer patients. This problem, as well as some other important aspects of the question of notifying a patient about his condition, is discussed in the article "Should the Cancer Patient be Told?" in *Medico-Moral Problems*, II, 7-10.

Before concluding, I should like to refer to a practical point concerning the relationship of the physician to the nurses and hospital

authorities. I am often asked by chaplains, nurses, and supervisors what they are to do when they know that a patient is dying and the doctor insists on withholding the information from the patient. The answer that I usually give to this question includes the following points: (a) discuss the matter with the doctor, pointing out to him what our Code requires; (b) if he admits that the patient is dying, but still refuses to communicate the necessary information, the relatives or guardians should be informed of this; and (c) if both the doctor and the relatives or guardians refuse to let the patient be told of his true condition, the hospital authorities should get legal advice concerning the possibility of adverse action in case they should act against the wishes of doctor and relatives or guardians. I insist on this last point because, despite the great importance of the spiritual welfare of the patient, we cannot risk the greater spiritual good of our apostolate by getting involved in an adverse lawsuit. I would welcome further suggestions as to how to deal with this delicate situation.

Another rather practical aspect of this question concerns the case in which a physician refers a patient to a specialist, e.g., a surgeon. Relatives are sometimes confused as to who should give them pertinent information. I am not sure of the professional etiquette in this matter, but I should think that, as long as the referring physician remains in charge of the case, it is his duty and privilege to give the pertinent information both to the relatives and to the patient.

2. *What is the teaching of the Church as to the time when the soul enters the body?*

In answering this question, one has to distinguish between the *speculative* and the *practical:* that is, between speculative thinking and practical rules. In the sphere of speculation, there are two theories, each backed by representative Catholic philosophers and theologians. St. Thomas Aquinas, for instance, was of the opinion that the rational soul is not infused into the body until the fertilized ovum has reached a certain stage of development. Just what this stage is, is not clear. For a long time this theory was very commonly held by philosophers and theologians; then it was more or less abandoned. Today, however, the general idea of this theory—namely, that there must be some development of the material before the infusion of the rational soul — is proposed as the more acceptable explanation of the beginning of the human life by many philosophers and theologians. The other view, also with many sponsors, is that the rational soul is always infused at the moment of fertilization.

We have no divine revelation on this point, nor any official pronouncement of the Church which condemns or approves either theory. Catholics are still free to speculate on the matter. However, in the practical order, we must follow the safer course of action and always treat a living fertilized ovum, whatever be its stage of development, as a human person, with all the rights of a human being. Thus, for example, canon 747 of

the *Code of Canon Law*, orders that every aborted fetus, no matter when expelled, should be baptized absolutely if it is certainly alive and conditionally if the presence of life is dubious. Also, when theologians give doctors a practical rule as to what may be done in the case of rape, they say the doctor may do anything medically possible to remove the aggressor's semen but may not do anything to remove or kill a fertilized ovum.

3. *Is baptism in utero ever justified, provided a presenting part is within reach and there is considerable danger that the child will be mutilated before delivery?*

Canon 746 of the *Code of Canon Law* gives a number of practical rules that are pertinent to the answering of this question. In the first place, the canon directs us not to give intrauterine baptism without necessity, that is, unless there is a real danger that the child may die before delivery. When this danger exists, however, intrauterine baptism should be attempted by one who is capable of doing it. When it is given, it should be given conditionally; and then, if the child is later delivered alive, he should be re-baptized conditionally.

Intrauterine baptism supposes that the child is still entirely within the uterus. A somewhat different problem concerns the case of partial delivery, with danger that the child will die before complete delivery can be effected. In this case, the canon directs us to baptize the presenting part. If this part is the head, the baptism is given unconditionally; but if some other part is presented, e.g., an arm or a leg, the baptism is given conditionally; then, if the child is finally delivered alive, he is to be rebaptized conditionally in the ordinary manner, namely, by pouring the water on the head.

A word about these conditions. Baptism is given conditionally whenever it is probable, but not certain, that it can take effect. Because of controversies among theologians, we can be certain about the effectiveness of baptism only when the water flows over the head. Since the Church has not seen fit to end these controversies by any official decision, we must follow the practical rule that only baptism on the head is certainly valid; hence, baptism conferred on any other part is given conditionally. As for intrauterine baptism, it is always difficult to be certain that the water flows over the head, consequently this should also be conditional.

It is not strictly necessary for the doctor or the nurse who gives intrauterine baptism or baptizes a presenting part other than the head to put the condition into words. It is sufficient to have in mind that one wants to give baptism insofar as that is possible, while using the ordinary formula: "I baptize you in the name of the Father, and of the Son, and of the Holy Ghost." The same practical rule may be followed by doctors and nurses when they rebaptize conditionally after a successful delivery. However, if one wants to put the condition into words, he may do so by saying: "If you are capable of being baptized, I baptize you in the name of the Father, and of the Son, and of the

Holy Ghost." This condition, *if you are capable of being baptized,* would cover all the situations visualized in this answer.

It may be helpful to note here that brief directions concerning many of the less usual, but very practical, situations concerning baptism are given in "An Instruction on Baptism," *Medico-Moral Problems,* I, 48-50.

4. *A doctor is called at night and given the information that a woman has just had a miscarriage, that the small fetus is discernible and apparently still alive. Should he go at once to baptize the fetus or should he give the directions for baptism to the person who has telephoned?*

The question does not state whether the doctor's presence might be required for medical reasons, though it implies that it is not. However, independently of this consideration, it seems to me that the better course concerning baptism is to give the instructions over the telephone so that the fetus can be baptized without delay. If the person who has telephoned has normal intelligence and is not emotionally unstrung, he (or she) ought to be able to perform the baptism properly, following the doctor's directions.

(To Be Continued)

Book Review

Morale et Médecine

by Jules Paquin, S. J.

Review by

Maurice B. Walsh, S.J.

Books like this are not written often enough. Here is a volume on medical morality which deserves, and is likely to receive, rave reviews from both moralists and members of the medical profession. Perhaps its merit can be summarized by saying that it is not just a "Question Box," not a cookbook of medico-moral recipes. Some moralists have too readily assumed that the doctor and nurse are too busy about their own professional occupations to have time for anything more than the "ready answer" to moral problems which arise in the course of those occupations. Father Paquin gives the ready answers—and they are generally solid ones—but he makes no unjustified assumptions. His basic assumption (and why not?) is that Catholic doctors and nurses are vitally concerned about the philosophy and theology which are the foundation for the answer—even the answer to the questions which have not yet been asked.

The author began his teaching career as a priest in a classroom of dogmatic theology; this no doubt influences his treatment of moral questions. Any moral theologian must base his work on dogma and sound philosophy; few succeed as well as Father Paquin in integrating these basic sciences into the pattern of Chrisitan morality. This may be the reason why the book is outstanding for the prevalence of "do" over "don't."

In broad outline, the work proceeds from a treatment of basic principles (Introduction, Part I; pp. 1-73), to general moral obligations with their application to the medical profession (Part II; pp. 77-111), to particular problems encountered in the practice of medicine (Parts III-VI; pp. 115-453).

Part I (Basic Principles) begins with a brief treatment of general ethical norms — how and why a human act is morally good or bad, either objectively or according to

the conscience of the agent. The traditional position on the norm of morality is then briefly contrasted with the situation ethics currently proposed by the Existentialists (Chapter I). But it is not enough abstractly to establish the morality of free human activity. Freedom must be exercised in order to have any influence on sending a man to heaven or hell. While it is not always possible for us to establish the precise degree of human responsibility in a given instance, Father Paquin does give some very sane norms for practical judgment — indicating how Freudian psychology, taken in small and well-filtered doses, is not necessarily totally poisonous for the Catholic moralist. Freud and some Freudians have been too willing to canonize for their Freudian heaven (wherever it is) poor, frustrated man whose Id plays the bully to his free will; but pre-Freudian moralists sometimes were — and are—too quick in condemning him to hell, not realizing the extent of his frustrations and the complexity of his complexes (Chapter II). Human liberty, even when exercised fully, will not of itself suffice, since our moral activity is directed to a supernatural end; hence supernatural merit is considered at the close of Part I, as the last and most important of the basic principles of Christian morality (Chapter III).

The professional activity of a doctor or nurse is not the carrying on of a trade or even the exercise of a profession merely; it is an apostolate. Part II, on general obligations, begins with this premise, drawn from the allocutions of the present Holy Father. Here the author treats in turn: professional qualities required in the doctor or nurse, justice and charity, principles of cooperation, the obligation of treating the sick, and the consent of the patient to treatment. Here and throughout, frequent reference is made to the numerous statements of Pius XII on medical matters (The bibliography lists 42 distinct documents of Pius XII, either addressed to the medical profession or treating directly of medical questions). Most moral obligations of doctors and nurses are obligations either of justice or charity. The chapter on these two virtues is brief, (only six pages long), but they are weighted pages — as is the distinction made between the two virtues: "Par *la justice*, je considère mon prochain en tant qu'*autre*, et je respecte ses droits stricts. . . . Par *la charité*, je considère mon prochain comme un *autre moi-même*, et je cherche à subvenir à ses besoins matériels ou spirituels." (pp. 88-89)

Particular professional obligations are all grouped around the general notion of respect for the human person. In the hierarchy of goods which the doctor and his assistants must respect, the supernatural life of the patient holds the first place (Part III, the Sacraments). But the medical profession has as its proper object the interior goods of the human person: life, the integrity of the members and functions of the human body, the physical and psychic health of man. Even after death, the human body remains an object of rever-

ence and respect (Part IV-V, Respect for interior goods). The same respect for the human person demands both discretion and integrity in using information acquired in a professional capacity—either in revealing the truth to the patient himself or in concealing it from those who have no right to the knowledge. Justice particularly, but also charity, motivates the determination of fees — since the patient is not only *"un autre"* but *"un autre moi-même"* (Part VI, Respect for combined and material goods).

As might be expected, the bulk of the work (about 350 pages) is concerned with particular obligations. Specific problems are solved on a basis of principle, with a positive and constructive attitude being maintained throughout. The author is as much concerned with what is right as with what is wrong. This constructive attitude is particularly evident in his treatment of the spiritual care of the sick and his discussion of questions of sexual morality. Some of the problems treated are: cooperation of the doctor and his assistants in the administration of the sacraments, their own administration of the sacrament of baptism — the circumstances and method in various cases, the spiritual care of non-Catholics, principles governing the preservation of human life, euthanasia, foeticide, abortion, premature birth, cesareans, mutilation and sterilization, birth control, periodic continence, sexual morality in the marriage and single state, artificial insemination, sterility tests, therapeutic incontinence, treatments with sexual reaction, human experimentation, drugs and drug addiction, psychic health, psychotherapy in general and psychoanalysis, hypnotism, narco-analysis, problems of Christian burial, the patient's right to the truth, the professional secret, split fees, unnecessary treatments and operations, negligence or incompetence in treatment, problems of restitution after injustice.

It would be almost impossible for a moralist to cover the entire field of medical morality without proposing some opinions which are at least open to discussion. Not all the opinions expressed will be universally commended. For example, good hospital practice in the United States normally entails a delay of longer than a week before the baptism of a healthy infant (cf., pp. 122-123). Granted the categorical refusal of the non-Catholic parents, the baptism of a dying infant might more frequently be omitted here than in Catholic Quebec (cf., pp. 130-131). Father Paquin is perhaps more liberal than many moralists would prefer in allowing the Sacraments to dying heretics and schismatics who are still conscious—but this is the priest's problem. The cooperation of the medical staff in the spiritual care of the sick will vary considerably with the circumstances of time and place. In discussing the administration of the Sacraments in hospitals, the author seems to have particularly in mind the small hospital under Catholic auspices; sometimes distinctions have to be made in order to apply the principles given to the situation exist-

ing in our large city hospitals — whether Catholic or not. Some moralists and canonists will consider as too liberal the opinion which allows a non-Catholic to act as proxy for a Catholic godparent in baptism (p. 188); some will consider as exaggerated the precautions advised in summoning a Protestant Minister to assist a dying non-Catholic (p. 187). Though a seriously scarred uterus may licitly be excised in some cases, too ready an argument by analogy to similar cases may be inadvisable (cf., pp. 260-261). It is a disappointment that the chapter on psychic health and psychotherapy (pp. 365-391) contains no adequate discussion of the client-centered or non-directive type of psychotherapy. The definition of a lie as "une expression contraire aux exigences de la societé" (cf., pp. 407-409) is likely to occasion some mumblings of discontent from the majority of Catholic moral philosophers and theologians (This reviewer is rather inclined to mumble a bit himself at this departure from the traditional definition).

If no eyebrows were raised at any opinion proposed, this would be rather an indication that the author had contented himself with repeating what everybody else always said. Independent thought and positive contribution to the progress of any science always results in some new differences of opinion. Those who may differ most vocally with one or two particular opinions expressed will also be most vocal in their enthusiasm for this real contribution to the moral theology of medicine.

MORALE ET MÈDECINE
L'Imprimerie du Messager:
Montreal, 1955. pp. 489

Minutes of the June Meeting — 1955

The June meeting of the Executive Board of The Federation of Catholic Physicians' Guilds was held in Atlantic City, New Jersey, June 8, 1955, at Hotel Dennis. The following were present:

J. J. Toland, Jr., M.D., Pres.
M. F. Yeip, M.D., 1st Vice-Pres., also representing the Cleveland Guild
Wm. J. Egan, M.D., 2nd Vice-Pres., also representing the Boston Guild
D. L. Sexton, M.D., 3rd Vice-Pres., also representing the St. Louis Guild
J. J. Graff, M.D., Sec'y., also representing the Wilmington Guild
Rt. Rev. Msgr. D. A. McGowan, Moderator

A. Reding, M.D., Sioux Falls, S. Dak. Guild
V. J. Mulaire, M.D., Stamford, Conn. Guild
E. J. Murphy, M.D., Bronx Guild
J. T. Geddis, M.D., Bronx Guild
N. MacNeill, M.D., Philadelphia Guild
C. P. Cunningham, M.D., Rock Island, Ill. Guild
H. L. Bastien, M.D., Northern Virginia Guild
F. J. Sullivan, M.D., Fall River, Mass. Guild
S. J. Carnazzo, M.D., Omaha, Neb. Guild
J. Satory, M.D., LaCrosse, Wis. Guild
J. Masterson, M.D., Brooklyn, N. Y. Guild
Rev. Henry M. Gallagher, Canton, Ohio Guild
Rev. J. J. Flanagan, S.J., Editor, THE LINACRE QUARTERLY
Wm. P. Chester, M.D., Detroit Past Pres. of Federation
Wm. J. Fordrung, M.D., Scarsdale, N. Y.
M. R. Kneifl, Exec. Sec'y.
Jean Read, Asst. Sec'y.

* * *

The meeting was called to order at 9:30 a.m.

President's Report

In his report the President commended the increase of subscriptions to LINACRE QUARTERLY which now total 6,655 and the increase in Guild membership to the Federation. Since the last Board meeting held in November 1954, ten more groups have been affiliated: Dayton, Ohio; El Paso, Texas; Stamford, Conn.; Eugene, Ore.; Fort Wayne, Ind.; Westchester, N. Y.; Pittsburgh, Penn.; Knoxville, Tenn.; Utica, N. Y., and St. Cloud, Minn.

Puerto Rico Affiliation

Affiliation of a Catholic Physicians' Guild in Puerto Rico was discussed. A Guild is being formed there where problems regarding planned parenthood and birth control are a cause of great concern. The moral support of the Federation has been promised.

St. Luke's Day—White Mass

Guilds reported on their observance of St. Luke's Day and the "White Mass" adopted by the Federation. The Bronx Guild ad-

vised that this Mass for the Catholic doctors in the Archdiocese of New York has been sanctioned by Cardinal Spellman. In Cleveland the Mass was celebrated in the Cathedral. Catholic doctors, their families and friends were invited. The Mass for the Boston Archdiocese was observed at Boston College last year. It will be repeated this year and Archbishop Cushing will be celebrant. The Detroit Guild advised that the occasion will be observed in three hospitals in that area this year.

News releases regarding this year's "White Mass" will be sent out in advance of October 18 for national and local publications.

Bulletin "Guilds in Focus"

The news bulletin "Guilds in Focus" is sent to the officers and presidents of affiliated Guilds. Representatives present were urged to have news of activities and information they would like to have circulated sent in to the Federation office to insure continued publication. The bulletin is circulated in the months that LINACRE QUARTERLY is not published. The venture received warm and enthusiastic approval of all present.

Financial Aid to Catholic Medical Schools

The committee appointed to investigate and report on the financial status of Catholic medical schools presented resolutions to sponsor definite plans for support. The Chairman, Dr. S. J. Carnazzo of the Omaha Guild, gave a fine report. This report will be prepared for presentation at the next Conference of Bishops to be held in Washington, D.C. in November. Guilds will be furnished with data to inform their respective Bishops of conditions and the need for assistance. Several plans were submitted which will be referred to the Executive Committee of the Federation Board for study to be presented with the resolutions.

Election of Officers

The Nominating Committee — Dr. Wm. Chester of Detroit, Dr. N. MacNeill of Philadelphia, and Dr. J. Masterson of Brooklyn— presented the following nominees for office: Dr. Melvin F. Yeip, Cleveland, President; Dr. W. J. Egan, Boston, 1st Vice-President; Dr. D. L. Sexton, 2nd Vice-President; Dr. E. Murphy, Bronx, N. Y., 3rd Vice-President; Dr. J. J. Graff, Wilmington, Del., Secy., and Dr. L. D. Cassidy, St. Louis, Mo., Treasurer. On motion duly made and seconded the secretary was instructed to cast one ballot and the above were elected for a term of office 1955-1957.

A hearty and prayerful vote of thanks was accorded Dr. Joseph J. Toland, Jr., retiring president, for his interest and conscientious efforts during his term of office. Dr. Melvin Yeip acknowledged election and expressed hope to continue the aims of the Federation with special emphasis on the further distribution of LINACRE QUARTERLY, the official journal of the Federation. It is his request that Guilds secure, if possible, and furnish the central office with names and addresses of all Catholic physicians in their respective dioceses. The names furnished would be other than those of Guild members.

Annual Meeting

Discussion ensued with regard to convening one Executive Board meeting yearly instead of two. Time is brief for the June meeting during the A.M.A. sessions and it

was suggested that this meeting might possibly be eliminated in favor of a two-day winter session. The Executive Committee will consider the proposal and report at the winter meeting to be held in St. Louis, Mo., December 10 and 11 tentative dates.

Exhibit at A. M. A. Convention

It was recommended that the Federation make arrangements for an educational exhibit booth at the next American Medical Association Convention. Catholic literature related to health care would be distributed and members of the Federation would be on hand for consultation. Details will be considered by the Executive Committee and definite proposals at the winter meeting.

News Release

Vigorous exception in the form of a release to the press was made, answering the American Society for the Study of Sterility, meeting in Atlantic City with the A.M.A., whose statement that "artificial insemination is a completely ethical, moral and desirable form of medical therapy" appeared in the June 4 *New York Times*. Copy of the release follows:

"**Atlantic City, New Jersey,** June 11 — Officers and delegates at the Federation of Catholic Physicians' Guilds annual meeting here took vigorous exception to a recent statement of the American Society for the Study of Sterility, which held that artificial insemination is a 'completely ethical, moral and desirable form of medical therapy.'

"Disagreeing with the statement on every count, the Catholic doctors said artificial insemination is a direct violation of the rights, privileges and duties of married life and, therefore, an attack on the very stability of society itself, which they as doctors are pledged to support. This fact alone, the Catholic doctors said, would make the practice unethical and immoral, and hence reprehensible rather than a 'desirable form of medical therapy.'

"The findings of the American Society for the Study of Sterility were made by a group of 500 medical doctors.

"The Catholic physicians contended that 'mutual consent' had no decisive bearing on the ethics and morality involved. The Catholic doctors said that they wondered seriously if the promoters and supporters of the 'test tube' baby idea have weighed the long range psychosomatic and legal implications of their crusade.

"The Catholic physicians noted that an Illinois Superior Court judge in a decision in a 'test tube' baby case said that 'donor insemination, with or without the consent of the husband, is contrary to public policy and good morals and constitutes adultery on the part of the mother.' The judge also said: 'A child so conceived is not a child born in wedlock and is therefore illegitimate.' "

World Health Organization

Msgr. McGowan described World Health Organization (WHO) and its activities, advocating watchful attention to its services in foreign lands. Apropos health and those engaged in the practice of medicine Msgr. McGowan noted that the present Pope has spoken more often and more informatively than preceding Pontiffs. The Holy Father's talks on health and other world-wide interests are reported in the quarterly publication "The Pope

Speaks." The subscription address is 3622 12th St. N.E., Washington 17, D.C. and it is highly recommended to Catholic physicians and others allied with health activities.

International Congress of Catholic Doctors

Dr. Wm. Chester, representing the Federation at the International Congress of Catholic doctors in Dublin in 1954, gave a resume of the meetings. He advised that the next Congress is scheduled for Holland in 1957 and urged those present to attend if at all possible. The group would be interested in coming to the United States.

LINACRE QUARTERLY

Father J. J. Flanagan, S.J., Editor of LINACRE QUARTERLY, commenting on the journal urged that more articles be written by doctors to make the issues truly represent Guild members. Subscriptions have increased during the last few years from some 2,000 to the current issue's mailing of 6,655. Some measure of this increase can be attributed to the growth in the Guild movement with the number mounting from sixteen to the present forty-five in the same period. Medical school subscriptions for students is another appreciable amount of the total, various Guilds generously defraying the expense, at a bulk rate of $1.00 for each subscription when ten or more are sent to one address for distribution. With Guilds furnishing the central office with the names and addresses of more doctors, continued effort will be made to increase the present total.

Reports of Guilds

Representatives reported regarding the activities of their respective Guilds. These will be treated in the bulletin "Guilds in Focus" from time to time.

Luncheon Meeting

Meeting adjourned at 12:00 noon. Luncheon for Catholic doctors, wives and friends attending the A.M.A. followed at 12:30 p.m. Speaker for the occasion was Dr. Charles Hufnagel, director of experimental surgery at Georgetown University Medical Center, Washington, D.C. "The Responsibility of the Catholic Physician in Research" was the title of Dr. Hufnagel's address to the gathering; high-lights are reported as follows:

"Research is fundamentally the search for new knowledge and/or the deduction or synthesis of new conclusions from known facts. It is upon the interest in research that the future of medicine and the health and welfare of the nation and the world rests. Catholic physicians and educators must assume a position of leadership if the Catholic physicians of tomorrow are to be provided with the educational facilities and stimulus with a Catholic background, understanding the problems of patients as individuals and fellow creatures of God. The pursuit of knowledge for its own sake has its merits but it is more laudable when it is directed with correlation to a known good.

We must strive to inspire the young physician to desire to participate in research activities and to point out to him the intellectual satisfaction which can be his reward. He must be given the benefit of disciplined training and be filled with a zeal to *want* to work, not be compelled. He must feel there are not enough hours in a day to do everything that must be

done. This must be based fundamentally on an overwhelming desire to help his fellowmen and not for any self-centered motive.

To arouse interest it should really be done in pre-medical education. There must be discipline in study and precision in work. In the medical school there is contact with basic research followed by opportunity for clinical research. The opportunity to study problems under guidance is the responsibility of those already in practice.

More research in Catholic medical schools is urged. It should be kept independent, free of excess control. More research should be encouraged in Catholic hospitals. The student should be trained to meet the problem of research to determine what is proper and how to carry the results to the clinical level. The institution should be encouraged to lend financial support and provide the facilities to help establish their doctors in a position of leadership in medicine so that they may fulfill their role in relief of their fellowmen.

To recall the period of technical advances it is not necessary to give detail but worthwhile to recall the antibiotics for infectious diseases coming into importance in 1940; the aseptic era and its relation to Pasteur; amazing advances in surgery of the chest and heart which began in 1939. These were the result of many combined investigations in many fields . . . basic sciences — physics, biochemistry, physiology, pharmacology and now entering the atomic age of medicine.

With these improvements, medicine has made many steps forward to becoming a more exact science, but it still lies in the twilight zone between art and science for it remains truly an art to attempt to differentiate and integrate the human biologic and psychological variable. Men in the fields of "so-called" exact sciences are becoming drawn more and more to medicine as they see in it a fertile field for application of their basic technics which they see have not been widely used in medical applications. This is stimulating and healthful. It is interesting, however, to observe how different is the biological equation from the physical. In the latter the individual components may be quite exactly set up, duplicated, and delimited. In the biological area this is not necessarily true and the manifold inter-relation of one factor to another may be unknown or highly variable.

It is worthwhile to note that much depends upon the point of view. For 200 years the Newtonian laws of motion had been accepted as unalterable and irrefutable. These seemed to be able to explain everything from the nature of heat to the behavior of gases. But as more sensitive instruments were developed and new observations were made, glaring violations of Newton's principles were uncovered. The methods used to measure phenomena in themselves often alter the phenomena so that constantly the search must go on to improve the observations from which conclusions must be drawn.

The keystone of these has been, is, and will be *research*, basic and clinical, for it is upon this that all medical progress is based and from which all future knowledge must accrue.

A second important factor is the dissemination of knowledge through education. This must be accomplished by training in medi-

cal schools developed by experienced instructors, and through graduate education both at the resident level and beyond.

Thirdly is the application of this knowledge to clinical practice at a high level of proficiency.

The names of Catholic scientists occupy high places in the history of medicine. Countless others unknown and unsung have devoted themselves and their lives to this purpose and their profession with a burning fervor.

Similarly, Catholic hospitals have long held positions of honor and affection even in communities which were predominantly non-Catholic because of their adherence to high moral, ethical, and professional standards. It is only by a thorough understanding of the value of research and by providing for it a medium of high quality that these high traditions can be maintained in an era of progress."

The Help You Need . . .

for Ethical Problems of Medical Practice

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The Laboratory and Male Fertility Tests
Gastric Analysis and the Eucharistic Fast

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Medico-Moral

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